New Mexico Legislative Council Service

INFORMATION BULLETIN

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MEDICAID REFORM COMMITTEE RECOMMENDATIONS

SUMMARY

Medicaid growth continues to be a front burner issue for both the federal government and the states. The delivery of Medicaid and health care services poses many problems for which the states need viable, affordable solutions. The expansion of Medicaid has brought health care services to millions of uninsured or under-insured people; and in many instances, has reduced the health care costs borne by the states for these populations. Uncompensated care for the uninsured triggers increases in health care costs. The expansion of the Medicaid program may lend itself to increased costs in the short term, and in today's competitive environment for governmental resources, this poses a serious challenge to policymakers. This bulletin recaps the cost-containment initiatives and other proposals of the 2002 Medicaid Reform Committee (MRC) and related Medicaid information about benefits, waivers and eligibility. The MRC final report, *Medicaid Reform Committee – Findings and Recommendations,* contains more detailed information that was presented to the MRC. Information Bulletin Number 3 – *Medicaid Growth* – offers its readers a basic understanding of Medicaid and issues associated with its growth rate. These documents are available at the Legislative Council Service and on its web site: http://legis.state.nm.us/news.asp.

MEDICAID AND MEDICARE DEFINED

The Medicaid and Medicare programs were adopted through amendments to the Social Security Act (SSA) in 1965 (P.L. 89-97) Titles XIX and XVIII, respectively; the ***expansion of Medicaid to uninsured children, the State Children's Health Insurance Program (SCHIP) (Title XXI)***, was enacted by Congress in 1997.

Medicaid is a jointly funded federal-state health insurance program providing health care for individuals and families with low incomes and limited resources (Centers for Medicare and Medicaid Services at: www.cms.hhs.gov). SCHIP is typically funded at a higher ***matching rate or federal medical assistance percentage (FMAP***) than most other Medicaid services. The FMAP rate for services rendered to Native Americans at Indian Health Services (IHS) or tribal-operated facilities is 100 percent nationwide, whereas services referred *through* IHS and provided by non-IHS facilities are federally matched at 75 percent in New Mexico. Most other services and administrative costs are reimbursed from 50 to 83 percent, with certain family planning costs receiving a 90 percent reimbursement.

Medicaid should not be confused with ***Medicare, which is another federal program of health care coverage for people 65 years of age or older, certain younger people with disabilities and people with end-stage renal disease (permanent kidney failure with dialysis or a transplant). Medicare has two parts: Part A, which has no charge if you qualify, and Part B, which may be purchased for a monthly premium.***

Some Medicare enrollees are eligible for and covered by Medicaid.

QUICK FACTS

Medicaid currently covers one in five New Mexicans.

The New Mexico Medicaid program is expected to cost $1.9 billion in federal and state dollars resulting in a $31.4 million budget gap in general fund appropriations for fiscal year (FY) 2003 (HSD, January 2003). This gap exists despite a $19.5 million contingency appropriation already enacted by the legislature for FY 2003.

The Medicaid program's revised projections for FY 2004 indicate a total need of $2.16 billion, of which $422.4 million is the state's share, driven by a projected 9.69 percent increase in enrollment.

The most populous counties in the state are Bernalillo, Dona Ana, Santa Fe and San Juan. Half of all Medicaid-eligible clients in New Mexico reside in Bernalillo, Dona Ana, McKinley and San Juan counties. McKinley, Torrance and Guadalupe counties have the highest per capita Medicaid eligibility rate. (*Quick Facts* 2003)

MEDICAID BENEFITS

Federally mandated Medicaid coverage generally includes physician services; inpatient and outpatient hospital services; laboratory and x-ray services; immunizations and early periodic screening, diagnostic and treatment (EPSDT) services for individuals under 21; family planning services and supplies; nursing facility/long-term care for individuals 21 or older, home health care, nurse midwife, and pediatric/family nurse practitioner services; federally qualified health center services and rural health clinic services. States may provide **optional**

reimbursable benefits, including prescription drugs; institutional care for individuals with mental retardation; home and community-based care for the frail elderly, including case management; personal care and other community-based services for individuals with disabilities; eye and dental care for adults; and physical therapy and hospice care (*The Medicaid Resource Book*).

MEDICAID WAIVERS

A Medicaid waiver is when the federal government allows or grants states permission to waive certain federal requirements in order to operate a specific kind of program (www.cms.hhs.gov). Waivers are often used to authorize managed care, or alternative delivery or reimbursement systems. In general, federal law allows states to enact **three types of Medicaid waivers: program waivers** or "freedom of choice" allowing states to operate a managed care model like Salud! in New Mexico [Sections 1915 (b) and (c); 1915 (b) and (c) concurrent waivers]; **research and demonstration waivers** for programs promoting the objectives of Medicaid (Section 1115 waivers - general); and **health insurance flexibility and accountability (HIFA) waivers** encouraging new comprehensive state approaches to increase the number of people with health insurance coverage within current-level Medicaid and SCHIP resources (Section 1115 waivers for the Demonstration Initiative).

MEDICAID ELIGIBILITY

There are at least 40 eligibility categories in New Mexico consisting of criteria set by federal and state laws and regulations (HSD, January 2003). ***"Categorically needy" describes groups of people who qualify for the basic mandatory package of Medicaid benefits.*** States are required to cover some of these groups with federally mandated basic services in order to qualify for federal reimbursement (FMAP) set by a formula each year based upon each state's average per capita income level. States with per capita incomes below the national level receive higher percentages. While **New Mexico has the third highest FMAP in the country** (www.aspe.hhs.gov), it is an indicator of the state's low ranking in per capita income.

The ***federal poverty level (FPL) is the federal government's working definition of poverty***, which is established annually (www.cms.hhs.gov). FPL is a significant criterion used along with age and disabilities when states determine eligibility for services. The federal poverty levels included in this bulletin are those published in the *Federal Register* for 2002. Optional eligibility categories may be offered by the states to expand coverage to qualified recipients. The optional services and associated benefits vary, with the differences driven primarily by the demography of each state (Sections 27-2B-15 et seq. NMSA 1978).

Individuals **most likely to be ineligible** include those who do not fall into a specified category, adults without children or **supplemental security income (SSI)** eligibility, parents who make more than the income eligibility guidelines, and nursing home residents who have not depleted most of their resources and other groups. ***SSI is a cash assistance program for low-income elderly and disabled individuals.***

The eligibility categories are generally grouped as follows:

Federally Mandated Populations:

- Low-income families with children as described in Section 1931 (SSA) and who meet state requirements;
- People receiving SSI;
- Pregnant women with income up to 133 percent of the FPL [e.g., $24,073 for a family of 4 and $11,784 for a family of 1 in federal fiscal year (FFY) 2002] and their infants;
- Children under age 6, up to 133 percent of the FPL (e.g., $15,880 for a family of 2);
- Children over age 5 born after September 30, 1983 up to 10 percent of the FPL (phased in through age 18);
- Children in adoption or foster care;
- Some low-income Medicare recipients are eligible for premium and co-payment assistance; and
- Special protected groups who may keep Medicaid for a period of time under certain circumstances.

Optional Populations:

- Additional people under Section 1931 of the SSA or demonstration waiver population allowed under the Section 1115 waiver;
- Additional infants, pregnant women and children (in New Mexico applies to pregnant women with income up to 185 percent FPL (e.g., $33,485 for a family of 4);
- Medically needy (not in New Mexico);
- Home- and community-based waiver recipients;
- SCHIP (children under age 21 who meet income and resource requirements under the former ***aid to families with dependent children (AFDC)***, but are not otherwise eligible); AFDC has been replaced with temporary assistance for needy families (TANF) under the Personal Responsibility and Work Opportunity Act of 1996 P.L. 104-193;
- Certain working disabled individuals (**"Ticket to work"** allows states to cover working disabled individuals with incomes above 250 percent of the FPL and to impose income-related premiums on them); and
- Institutional care for individuals above the SSI level (75 percent of the FPL).

WHO DETERMINES ELIGIBILITY?

The Medical Assistance Division of HSD promulgates regulations for Medicaid; the Income Support Division of HSD makes eligibility determinations for Medicaid, except for categories that are administered by the Children, Youth and Families Department (e.g., foster care and adoption subsidies) and the Social Security Administration (e.g., for supplemental security income recipients).

WHAT PORTION OF MEDICAID IS PAID BY THE RECIPIENT?

The "categorically needy" may not be charged enrollment fees or premiums; however, these fees and limited premiums, based on family size and income, may be imposed by the states if Medicaid waivers are approved by the federal government.

Federal law and regulations restrict or limit cost-sharing based on factors such as age of the recipients, type of service, income level of the recipients and more. New Mexico does have some copayments in SCHIP and other categories. There are no deductibles or coinsurance payments required, because there cannot be more than one type of charge per service (e.g., bundling deductibles and coinsurance is prohibited).

Although cost-sharing requirements may reduce costs for government in the short term, they may discourage recipients from obtaining necessary and preventive health care that reduces longer-term health care costs. Providers are required to collect copayments, which may cost more to collect than the actual payment, compelling providers to absorb the unpaid amounts.

WHO PROVIDES MEDICAID SERVICES IN NEW MEXICO?

Medicaid services are provided through managed care, called *Salud!* in New Mexico, and fee-for-service (FFS) programs. Currently, three managed care organizations (MCOs) provide services under a contracted per member per month rate to two-thirds of the Medicaid population; one-third is served under FFS. Some recipients receive primary care from an MCO, but receive additional services under FFS, when they are not available from the MCO.

MEDICAID REFORM COMMITTEE

The legislature established this committee in 2002 to review Medicaid program services, delivery, funding and policy. After months of study, the 30-member committee of legislators and private citizens made recommendations, many of which were adopted by the Legislative Finance Committee and incorporated into its state budget proposal for FY 2004. The committee's work:

- "focused on maximizing the available funding for Medicaid by generating additional federal funding to enhance the state's Medicaid budget";
- "incorporate[d] strategies for financing and delivery incentives to reduce or contain costs"; and
- "included fine-tuning managed care and selectively contracting for certain services to reduce costs and improve how the care is managed ". (MRC Report)

The Recommendations Are:

A. Twenty-four program changes for the Medicaid program, enhancements and cost-containment initiatives aimed to provide between $8.5 million and $22.5 million in savings to the state general fund;

Components:

1. Require a uniform preferred drug list for Medicaid (FFS and *Salud!*);
2. Integrate Item 1 with other state agency programs that purchase prescription drugs;
3. Identify entities eligible for the federal drug pricing program authorized under Section 340B of the federal Public Health Service Act;
4 Develop a prescription drug purchasing cooperative to maximize the state's buying power;
5. Expand use of community health providers;
6. Require MCOs to strengthen disease management programs with primary care providers (PCPs), particularly in underserved areas, and adopt uniform key health indicators;
7. Ensure case management services are provided to Medicaid recipients by MCOs and FFS, targeting specific classes of individuals and areas where costs reflect a need for coordination and management;
8. Design a pilot disease management program based on key health status indicators for FFS populations;
9. Continue the personal care option with increased consumer awareness of services;
10. Expand the program of all-inclusive care for the elderly (PACE) in urban areas (e.g., Las Cruces, Roswell or Santa Fe);
11. Coordinate or consolidate the state's long-term care services under one agency for all ages of recipients;
12. Strengthen fraud and abuse detection and recovery plans;
13. Identify all services that may be reimbursable under Medicaid;
14. Maximize all reimbursements for delivery of services to Native Americans to achieve 100 percent reimbursement;
15. Develop a payment methodology that will allow true reimbursement of 100 percent of the eligible federally qualified health centers (FQHCs);
16. Ensure reimbursement for primary care clinics engaged in Medicaid outreach and enrollment activities;
17. Impose a monthly premium on selected Medicaid beneficiaries who meet HSD criteria;
18. Assess tiered copayments on emergency room services, under certain situations;
19. Assess tiered copayments on selected higher-cost prescription drugs;
20. Assess copayments for drugs not on the preferred drug list;
21. Direct that all cost-sharing requirements be in compliance with federal law;
22. Reduce optional vision benefits;
23. Revise Medicaid policies to encourage the use of generic prescription drugs; and

24. Ensure that nursing home criteria for consideration of assets are the maximum permitted under federal law.

B. Proposed studies, pilots and waiver requests by HSD for cost-benefit analyses that may cost the state up to $500,000 (or less if private grants are obtained); these initiatives have the potential of saving the state millions in general fund dollars over the long run.

Components:

1. Conduct a cost-benefit analysis of:
   a. carving out the pharmacy drug benefit from the managed care system to a centralized administration for both MCO and FFS system;
   b. replacing the managed care system with a statewide primary care case management (PCCM) model;
   c. comparing non-emergency transportation services under a state-managed model, brokerage models and other models;
   d. the global funding waiver currently in process in HSD to determine if the waiver should be requested;
2. Implement a pilot project for:
   a. a primary care case management model for the FFS population; and
   b. an urban and rural area non-emergency transportation service for selected Medicaid recipients in FFS;
3. Identify options for reducing, limiting or eliminating Medicaid services assuring that the most vulnerable recipients are not adversely affected;
4. Conduct an external analysis of selected Medicaid prescription drug use in the state with respect to various trends;
5. Determine feasibility of a federal waiver to consolidate certain persons currently served by the state through other agencies and paid with general fund dollars; and
6. Work with the counties to get a waiver or to include the use of medical indigent funds in maximizing benefits and reimbursements under Medicaid, while ensuring accountability and certain flexibility.

C. Four tax initiatives to supplement Medicaid funding in light of double-digit medical inflation; these may provide between $68 million and $118 million in additional state funding.

Components:

1. Increase the cigarette tax by $.60 per pack and earmark some or all for Medicaid;
2. Impose an excise tax on alcohol and earmark for Medicaid and a statewide trauma system;
3. Authorize individual tax credits for long-term care insurance; and
4. Require a premium tax on Medicaid MCO PMPM payments to provide for approximately 75 percent reimbursement of the premium tax by the federal government.

D. Two initiatives to earmark gaming and tobacco settlement money for Medicaid funding support.

Components:

1. Earmark a percentage of gaming revenues; and
2. Increase the percentage of tobacco settlement funds dedicated to Medicaid support.

Committee sponsored legislation has been introduced in the 2003 legislative session to adopt the recommendations, which might be amended before final passage. Portions of the recommendations have been incorporated within the FY 2004 legislative budget proposal for Medicaid.

REFERENCE LIST

Bureau of Business and Economic Research (BBER), University of New Mexico. NM County Population Estimates for 2001.

Centers for Medicare and Medicaid Services at: http://cms.hhs.gov/Medicaid.

Chapter 27 NMSA 1978 and related statutes of New Mexico.

Federal Family Support Act of 1988 (P.L. 100-485).

Federal Omnibus Reconciliation Acts of 1986-1990 and 1993 (P.L. 99-509; 100-203; 101-239; 101-508; 103-66).

Federal Responsibility Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

Federal Social Security Act of 1965 (P.L. 89-97) and subsequent amendments at: www.ssa.gov/OP_Home/ssact/comp-toc.htm.

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The Medicaid Resource Book. July 2002. Web site: www.kff.org.

New Mexico Health Policy Commission. *Quick Facts 2003.* January 2003. Web site: www.hpc.state.nm.us.

New Mexico Human Services Department.
Report to the Medicaid Reform Committee by the Medical Assistance Division. November 6, 2002.
Medicaid Program - Revised Projections Memorandum. January 16, 2003.

U. S. Department of Health and Human Services web site: www.aspe.hhs.gov.

This document contains information and excerpts from reports and presentations made to the 2002 interim Medicaid Reform Committee as well as additional cited sources. Roxanna Knight condensed them in consultation with Raul Burciaga. The final report of the interim MRC may be obtained by contacting the Legislative Council Service at (505) 986-4600. This document does not represent a policy statement of the Legislative Council Service or its staff.

ADDITIONAL INFORMATION BULLETINS

No. 1 - Public School Capital Outlay Funding Events and Accomplishments
No. 2 - Introduction To New Mexico Water History and Terminology
No. 3 - Medicaid Growth

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